

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

2002 — 06 —

2. STATE:

Florida

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

April 1, 2002

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

Section 1931 of the Social Security Act

7. FEDERAL BUDGET IMPACT:

a. FFY _____ \$ _____
b. FFY _____ \$ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 2.2-A, page 2a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 2.2-A, page 2a

10. SUBJECT OF AMENDMENT:

Extended Benefits

11. GOVERNOR'S REVIEW (Check One):

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☒ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Mr. Bob Sharpe

14. TITLE:

Deputy Secretary

15. DATE SUBMITTED:

April 8, 2002

16. RETURN TO:

Mr. Bob Sharpe
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop # 20
Tallahassee, Florida 32308

Attn: Wendy Johnston

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

April 12, 2002

18. DATE APPROVED:

June 10, 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

April 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Eugene A. Grasser

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

State: FLORIDA

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	407(b), 1902 (a)(10)(A)(i) and 1905(m)(1) of the Act	3. Qualified Family Members See Item A.10, page 5.
	1902(a)(52) and 1925 of the Act	4. Families terminated from Section 1931 Medicaid solely because of earnings, hours of employment, or loss of earned income disregards are entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This coverage is contingent upon this provision of Section 1925 remaining in effect.)

*Agency that determines eligibility for coverage.

TN No. 2002-06

Supersedes

TN No. 98-30Approval Date JUN 10 2002Effective Date April 1, 2002Revised Submission 5/31/02